

Clinical Section

Recent Trends in Obstetrics and Gynaecology

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In the title of this paper I have deliberately used the term trends rather than advances because it is difficult to say in any given case what does and what does not constitute an advance. Time alone can decide this. By trend I mean the direction in which the subject is tending; how do results today compare with those of say a decade ago, how will they compare with those a decade hence? Are we progressing, standing still, or retrogressing? Is the drift salutary or dangerous?

In general, I would say we have made definite progress in nearly every phase of obstetrics and gynaecology; in a few we have been static; in only one perhaps have we at times moved backwards (i.e., increased and unnecessary operative delivery). At the conclusion of this paper I shall indicate some of the problems still requiring solution.

Let us first examine, in a broad way, some of the changes in these specialties, and then in more detail a few concrete examples of each.

1. Conservatism

The general trend in obstetrics and gynaecology has been not only one of improvement and enlightenment but also one of increasing conservatism. The development and rapid progress in asepsis, antisepsis, anaesthesia, sutures and instruments have made surgery relatively safe for the patient; advances in pre-operative and post-operative care have made the patient safe for surgery. But with this there followed a furor for active, radical methods of treatment which was enhanced by the increasing hospitalization of patients and the stepped-up tempo of the last twenty-five years. We are now experiencing a levelling-off or mellowing process and have in many procedures re-adopted the old conservatism tempered, however, with a more judicious selection of cases for radical treatment.

There are at least four explanations for this swing back in practice. (a) The rising mortality, and often life-long disability, from too radical procedures. (b) A clearer conception and appreciation of how much Nature alone can accomplish if properly aided and guided; of her great defensive and protective mechanisms elucidated by a newer physiology, immunology, and science of nutrition. (c) The great advances in internal medicine have rendered unnecessary many procedures heretofore considered almost indispensable. For example, pregnancy complicated by tuberculosis, diabetes, hyperemesis, to name only a few, was in the past almost always terminated by therapeutic abortion. Today, we have learned to follow a policy of ignoring the pregnancy in

these cases and actively treating the medical complication. Here conservatism results from progress in general medicine. (d) Surgery has in some cases been supplemented, or even supplanted, by less radical but equally effective therapy. Wertheim's panhysterectomy for carcinoma of the cervix is now almost an obsolete operation, and has given way to radiation treatment as the method of choice. Removal of acute gonorrhoeal tubes is now fortunately no longer practised; sulfanilamide, Elliott therapy and temporization yielding equal if not superior results without maiming the individual. The chronically diseased cervix is cauterized or coned rather than amputated; distension follicular cysts of the ovaries are disregarded surgically and recognized as of physiological or at most of abnormal endocrine origin, oophorectomy and even resection being not only archaic but destructive operations. The indications for hysterectomy are now clear-cut and limited, even fibrosis uteri yielding 99% cures with radium at one-quarter the risk. With the exception of the removal of retained products of conception, curettage is now almost entirely a diagnostic and not a therapeutic procedure. The day of routine scraping of every bleeding or otherwise abnormal uterus with the object of cure has now gone. Uncomplicated retroversion of the uterus is known to be almost a normal position in some women; routine suspension is unjustifiable; in selected cases it yields excellent results. The Hodge era of tinkering gynaecology is over, so also of excessively radical gynaecology as practised by Tait (e.g., Battey's operation for any and every female complaint).

2. Co-operation

A second trend has been in the closer co-operation between obstetrics, gynaecology and the other branches of medicine. Biochemistry, bacteriology, pathology, internal medicine, general surgery, radiology, urology and psychiatry are all lending their aid in solving many of our most difficult problems. No obstetrician or gynaecologist today is doing the best for his patient unless he uses, when indicated, the facilities and knowledge that these sister subjects can offer. The Friedman test, biopsy of tumours, blood and lochial cultures, ureteral catheterization, and the assessment of pre-operative risk, are only a few examples of our dependence on them. To get this collaboration there must be an open-mindedness, a give and take attitude, a co-ordination of teaching and practice of all departments in schools and hospitals.

3. Prevention

The modern concept of preventive medicine has not been lost in obstetrics and gynaecology. In

fact, they reflect some of the triumphs in this field. There has been a widening of communal interests and responsibilities; an increased attention to pre-and postnatal care, maternal and infant mortality and welfare; enhancement of the value of the child due to falling birth rate, smaller families and rising incidence of late first pregnancies. No longer is an obstetrician a mere midwife who attends and assists at delivery; today he must have considerable knowledge of the cognate sciences of eugenics, sociology, public health, embryology, teratology, endocrinology, dietetics, etc., etc. His prestige and place in the medical profession have been steadily growing with the years. He is responsible at one time for two lives (which all too often are reciprocally related)—the most important lives in the family as a social unit; responsible not only for their survival but also for their permanent future health. His successes are taken for granted; his failures are deemed inexcusable by the very nature of the work. (Indeed in a recent editorial in a local newspaper maternal mortality was branded as murder). Next to tuberculosis, maternity is responsible for the greatest number of deaths in the childbearing period of a woman's life. I suppose no other so-called physiological process is attended with as many potential hazards and perils as that of having a baby.

A fourth trend has been the closer interweaving and mutual interdependence of obstetrics and gynaecology. 60% of gynaecologic complaints are attributable to pregnancy and labour; the diagnosis and treatment of pelvic disease during pregnancy requires some knowledge of gynaecology. The physiology of menstruation, conception, pregnancy, labour, puerperium, menopause is a continuous, indivisible process. He who devotes his time to this series of phenomena and their anomalies must know something of both obstetrics and gynaecology, and is in far the best position to treat them safely and successfully.

Cephalo-pelvic Disproportion

(disparity in size between foetal head and maternal pelvis)

The relation in size between the foetal head and the maternal pelvis is, of course, a fundamental one. It must be carefully estimated in all first pregnancies, better still in all pregnancies. Its importance has always been clearly recognized, but for years the main emphasis was placed on the absolute size of the mother's pelvis only. In course of time the size of the foetal head in relation to maternal pelvis came to be stressed, and today we still believe the best pelvimeter is the baby's head. (Muller's, Kerr's, Fahmy's, Hillis' methods of gauging disproportion all utilize it). External pelvimetry should be done routinely, but most authorities admit that its accuracy and value are small. It must be clear that in any given case not only must we consider the relative sizes of head and pelvis but also the more or less unpredictable strength of the uterine contractions. Strong pains may overcome great obstacles. In

a primigravida this factor is uncertain, so that nowadays it is the custom to allow such a patient with minor or "borderline" disproportion to go into labour. An opportunity is thereby afforded of evaluating the strength of the powers as actually exhibited during parturition. Such a trial labour or test of labour must be conducted only in a hospital, no internal examinations other than rectal are allowed, and the utmost asepsis observed. About 80% of these cases will have a spontaneous or an easy forceps delivery; the remaining 20% will require Caesarean section. Since every additional hour of labour prejudices the patient's chances for a classical section it has been the practice to utilize the low segment section in which the risk of infection is minimized. Some may deprecate this management as radical rather than conservative. But let us analyze the facts. Formerly these cases were handled in one of three ways, all surgical—(1) induction of premature labour to obtain a smaller but more fragile foetus, (2) classical section done electively prior to or just after the onset of labour, and (3) craniotomy on neglected cases—failed forceps, etc. In a word, no cases were delivered spontaneously in methods 2 and 3, whereas 4 out of 5 would have been if permitted a trial labour. Thus we see it is a more rather than a less conservative practice. Cases of marked and even moderate disproportion will still be treated by elective section, and in multiparae induction of premature labour may have a place, since here we know two factors as shown in previous labours, viz., type of uterine pains and the birth weights of the children.

More accurate pelvimetry and cephalometry now possible by X-ray films may to some extent modify trial labour, but the force of the pains and the adaptation and moulding of the passenger can not be foreseen in a film.

This leads naturally to a discussion of:

Low Segment Caesarean Section

This type of Caesarean section has been rapidly gaining followers both in Europe and America in the past decade. Several different techniques are in use, but in all, the same principles are observed and the same objects achieved.

It differs from the classical section in that the uterus is opened by an incision through the lower, thin, non-contractile segment rather than through the upper, thick, vascular, contractile segment.

Although my personal experience and observations are limited, nearly all writers agree that it is superior in practically all respects to the classical method. Its one disadvantage is that it is technically more difficult and cannot, as a rule, be performed with the rapidity of the older method.

What are its advantages?

1. Perhaps the most important is the greatly reduced incidence of post-operative sepsis and peritonitis which we know to be the outstanding cause of death following the classical operation.

The incision is securely covered by (a) a layer of utero-vesical fascia, (b) the bladder itself and (c) peritoneum overlapped. Thus leakage of the lochia into the peritoneal cavity is less likely. In addition, the lower segment post-operatively is passive and lochia is less liable to be squeezed out through the incision (contrast the actively contracting and relaxing upper segment).

In view of these facts, low section can be performed with relatively greater safety, as regards infection, in any case, and with much greater safety in a potentially infected case than can classical section. Hence it is the preferred route of delivery after a trial of labour.

2. More solid healing of the uterine incision. This is because the thinner wall facilitates accurate coaptation by suture, and secondly the quiescence of lower segment post-operatively favours healing. Holland estimated that 4% of classical section scars rupture in a future pregnancy or labour. The incidence of rupture after low section is only about 1/10 as great (0.4%).

3. *Adhesions* of bowel, omentum and parietes to the incision occur much less often since the suture line is well covered and low down out of their way. Late post-operative pain and obstruction thus occur less commonly.

4. The immediate post-operative course is shorter and smoother with low section, since bowel is seldom exposed or seen during operation. Distension and paralytic ileus are thus reduced to a minimum.

5. The child is delivered in the safest way, viz., by the head.

6. The placenta is not encountered unless it be low or a praevia.

7. The *mortality* as compared with that of classical section is definitely lower in clean cases and greatly lower in suspect or frankly infected cases. (Chicago Lying-In 0.7% 800 cases; Marshall of Liverpool 200 cases without a single maternal death. 2 to 4% for the classical in the best hands and in the most favorable circumstances).

In this connection I should like to remark that in regard to Caesarean section the method of its performance is perhaps considerably less important than the judgment exhibited in the selection of the case for operation. It must be remembered that in practical obstetrics two sets of circumstances influence every proposed procedure. They are (1) the indications and (2) the conditions. The latter are such factors as, whether patient at term or not, in labour or not, the type of pains, the degree of dilatation of cervix, integrity of the membranes, type of presentation and position, state of the foetus, alive, dead, or in distress; state of mother—associated diseases, etc. If any one (or several) of these conditions is unfavorable it constitutes a contra-indication. All these factors must be carefully weighed one against the other before adopting any type of interference. This obviously requires an extensive knowledge and

experience in abnormal obstetrics. Any operator with general surgical experience can easily perform a Caesarean section; but few are competent properly to judge in which cases section is imperative, elective, or definitely contra-indicated.

There is unfortunately a tendency today to perform sections frequently and indiscriminately without regard to the obstetrical indications; a deplorable tendency to use suprapubic delivery as an easy solution of a difficult labour; a tendency to forget that even in the best hands and in the most favorable circumstances the mortality is ten times that of normal delivery from below. It is true that certain women expect or demand "delivery by appointment" or operation to avoid the ordeal and uncertainty of natural labour; it is true that the indications for section have been extended in recent years with the increasing safety of surgery and increasing value of the foetus, but it is also true that all leading obstetricians condemn unconditionally the alarming rise in the incidence of this operation, warning of its many dangers in unsuitable cases. They measure their standard of practice by how few and not by how many abdominal deliveries they are called upon to perform.

Pelvic Shape or Type

In discussing disproportion the factor of pelvic size and relative sizes was mentioned. Largely through the work of Caldwell & Moloy, Thoms, Jarcho et al, we have come to recognize that an equally important factor is the shape or biological type of the pelvis. The pelves of all women are not of the same female type with varying dimensions as previously taught, but, on the contrary, differ architecturally from individual to individual. X-ray study has revealed four main types, but many combinations and permutations of these exist. The big four are gynaecoid, android, anthropoid and platypelloid (41.4%, 32.5%, 23.5% and 2.6%). Time forbids description of these types but a few points should show the significance of this study. We know, for example, that with an anthropoid pelvis (antero-post. lengthening) an occipito-posterior position should not be rotated but delivered as such. Again pelvimetry may reveal a normally-sized pelvis but if android in type one may anticipate increasing difficulty as labour progresses. A woman may have a male type of outlet but a female inlet, or her fore-pelvis may be of male type but hind-pelvis female (gynaecoid-android type). This new concept of pelvic conformation has revolutionized many of our ideas regarding the mechanics of delivery, dystocia and disproportion.

Placenta Praevia

The present tendency in managing this formidable complication of late pregnancy is to follow an "all or none" policy. That is to say, Caesarean section for the severe type, simple rupture of the membranes in the mild type. Extreme examples of these types are:

(1) *Severe*—A primigravida, not in labour, with central implantation, cervix long and closed, Caesarean is the treatment par excellence.



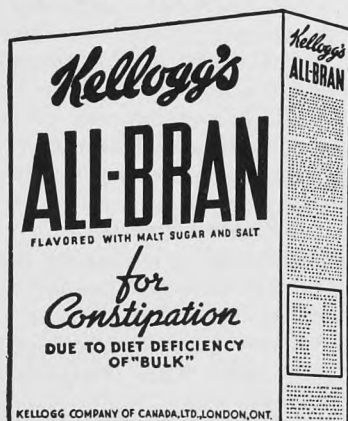
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(2) *Mild* — A multipara, in labour, incomplete or low implantation, partly dilated cervix. Here rupture of the membranes usually suffices. Cases of intermediate severity will have to be studied individually and treated on their own merits. The reason for this type of management lies in the frightful foetal mortality and considerable maternal mortality from version, packing, bagging, etc.

Two other points are stressed in modern management. (1) Hospitalization, where possible, of all suspected cases. Do not pack or examine in the home. (Packing may be legitimate in certain severe cases). Prepare for delivery before examination in hospital. (2) Immediate blood typing and matching of all cases on admission with early transfusion. "Better to transfuse early and unnecessarily than too late or not at all."

This management can only be carried out in well appointed hospitals. In rural practice Braxton Hicks version is still the method of choice.

Drugs

Only two will be mentioned in this paper.

1. *Ergometrine* (Ergonovine), isolated from ergot by Chassar Moir and H. Dudley in 1935, is the pure alkaloid of the ergot fungus and possesses to a remarkable degree the oxytocic properties of ergot, relatively free from its undesirable side effects. Given orally ergometrine produces a uterine response in less than 8 minutes, intramuscularly in 3 minutes (same as pituitary extract), intravenously in 45 seconds. The effect lasts some three to four hours. This alkaloid thus combines the rapid action of posterior pituitary extract with the prolonged effect of ergot preparations. It should not be used before the completion of the third stage of labour. The chief indication is post-partum haemorrhage, but it may be used routinely following expulsion of the placenta, in the puerperium, and in the profuse bleeding of incomplete abortion. The advantages of this drug over pituitary extract as an oxytocic are: (1) It acts as quickly after injection. (2) Its action persists for three hours, pituitary for only 20 to 30 minutes. (3) It is effective, given orally. (4) There is no danger of shock as has been described with pituitary extract.

2. *Sulfanilamide and its Allies*. As in other branches of medicine so in obstetrics and gynaecology these drugs have revolutionized the management of infections. Their introduction is perhaps the greatest single contribution to therapeutics since the use of arsenicals in syphilis.

Puerperal sepsis mortality was reduced at Queen Charlotte's from 23% to 5% (Colebrook using prontosil). In gonorrhoea and pyelitis of pregnancy these drugs have proved to be the best remedies so far discovered.

Sulfanilamide and sulfapyridine show a special predilection for the B hemolytic streptococcus; sulfapyridine for the pneumococcus and gonococcus; sulfathiazole for the staphylococcus.

Orthopaedic Surgery: A Decade of Progress

by ANDREW P. MacKINNON, M.D., Ch.M., F.A.C.S., F.R.C.S. (Can.)

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Time marches on: so does Orthopaedic surgery. We have made some real progress in the past decade, a review of which may be of interest to our readers.

The Intervertebral Disc

Ten years ago we did not know much about the intervertebral disc. To be sure Schmorl's work was published in 1927 and '28, but its significance did not influence surgical practice at once. We now know that the loss of the shock absorbing function of the nucleus pulposus explains many cases of osteoarthritis of the spine; that the biconcave or so-called "fish" vertebrae of osteoporosis or malignant disease are due to the expansile properties of this organ; and that the narrowing of the intervertebral space so characteristic of Potts' disease is probably due to early tuberculous involvement of the nucleus pulposus. It was only during the latter half of the last decade that backward protrusion of a part of the intervertebral disc came to be recognized as a frequent cause of intractable low back pain and "sciatica." It is now common knowledge that every case of "sciatica" especially when objective signs of pressure on the fifth lumbar or first sacral nerve are present, should be studied from this point of view; and that many of them can be completely cured by removing the offending nucleus pulposus.

Fractures

In the management of fractures we have progressed a long way during the last ten years. Bohler's methods, with his insistence on accurate reduction by skeletal traction followed by fixation in non padded casts, and early function, have almost revolutionized the treatment of fractures. The introduction of local anaesthetics injected directly into the hematoma has been a great boon. In fractures of the neck of the femur, internal fixation by means of the Smith-Petersen nail has entirely replaced the Whitman abduction treatment. Although Smith-Petersen first used the three flange nail in 1925, his results were not published until 1931, and the operation as practiced by him up to that time was a formidable procedure. In 1932, however, Johansson of Sweden paved the way for "blind nailing" by the use of the guide wire and canulated nail. This method with fluoroscopic control made popular by Lieut. Col. George Ryan, R.C.A.M.C., who read his paper in Winnipeg before the Winnipeg Medical Society in March, 1939, has so simplified the procedure that it can be safely used even in old and feeble patients.

Vitallium became available in 1937 when Venable and his associates published their first report. Previous to that time metal plates and screws used for internal fixation of bone often failed because

of reaction around the metal, attributed to delayed sepsis, resulting from alleged imperfect technique. Venable proved that this reaction is due to electrolysis, and that it does not occur when Vitallium is used. The result has been epoch making in this branch of surgery. Vitallium has many uses. Whenever nails or screws are needed in bone surgery, including the Smith-Petersen nail, it fulfils the requirements. The writer has employed it in some seventy cases, and has found it uniformly satisfactory. The Vitallium cup introduced by Smith-Petersen for arthroplasty of the hip, gives promise of fruitful results, but is still *sub judice*.

Bone and Joint Tuberculosis

Tuberculous Arthritis even as late as twenty years ago occupied a large part of the time and energy of the orthopaedic surgeon. But in the past ten years a change has been very apparent. Indeed such cases have almost become rare in orthopaedic practice. Statistics show that tuberculosis in general is much less common in all civilized countries than it was. Our province is no exception. Nor could it very well be otherwise. The campaign initiated by the late David Alexander Stewart over thirty years ago, and carried on relentlessly throughout his life, has borne fruit. And his influence is probably now greater than it was in his lifetime, because the organization that he built up and the men whom he trained, are carrying on his work in a bigger way than their late chief could have hoped. Manitoba now has an adequate number of Sanatorium beds, so that all open cases of Tuberculosis can be, and for the most part are, in hospital and kept away from their families, until they are no longer infectious. This "segregation of carriers" supplemented by systematic examination of contacts and suspects, and the thorough follow up of discharged cases, so ably done by the travelling clinics, gives us reason confidently to hope that soon tuberculosis will be no longer one of the major causes of invalidism and death.

It is becoming increasingly realized that the patient with bone or joint tuberculosis, is an individual infected with tuberculosis who probably has other lesions, more or less active, most often in the chest or genito-urinary system, which call for careful investigation and supervision. This can best be done not by an individual but by a group of experts, such as is to be found on the staff of the modern Sanatorium. So it has come about recently that most of the cases are treated in Sanatoria rather than by the individual surgeon at home or in a general hospital.

What a pity we cannot record equal progress in other forms of chronic arthritis! Here verily is a field that lies untilled; a vast sea of human misery to be charted. Rheumatoid arthritis still

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Infantile Paralysis

So in Tuberculosis progress has been largely in prophylaxis. We have reason to hope that before long the same may be said of Infantile Paralysis. One has been struck in the past by the similarity of the seasonable incidence of cases, with that of the epidemics of typhoid fever of forty years ago. Both showed the occasional case in the spring and early summer, followed by a marked increase in the number of cases during the late summer and early autumn, reaching its culmination in October, and then the sudden cessation of the epidemic in November. Now we have the recent report of Paul and Trask who have been finding the virus of Infantile Paralysis in the stools of patients and carriers, and in sewage. What a boon to humanity if epidemics of this dread disease should follow those of typhoid fever into the limbo of forgotten things.

The Sulfonamides

The sulfonamides, during the past eight years have proved a veritable boon in orthopaedic surgery. Many a septic hand has been saved by their use, supplemented by appropriate surgical treatment. Pneumonia, always a dreaded complication in surgery, has lost much of its terror since Dagenan has demonstrated its efficiency. Not only so, but the prophylactic use of Dagenan has enabled us to operate on many patients to whom formerly we would have denied the benefits of surgery, because of the fear of this dread complication. Recent work suggests that perhaps in sulfathiazole we have a weapon of real value against the staphylococcus, the most dreaded enemy of bone. The sulfonamides are given regularly now, internally, as a prophylactic after operations and compound fractures, where there is reason to fear the development of sepsis, and undoubtedly they are of value. More recently the local use of these drugs in powdered form in the wound to prevent the development of infection has been reported upon and gives sufficient evidence of usefulness to warrant further trial.

In concluding, some mention should be made of the newer conceptions of the physiology and biochemistry of bone. Studies in hyperparathyroidism have helped to clarify our knowledge of other conditions in which bone cysts and giant cell tumors occur. Delayed union and non-union of fractures call for further study. So does the painful and annoying osteoporosis that is such an important factor in prolonging disability after fractures. Recent studies seem to place the cause of these misfortunes in local conditions. Inefficient fixation, and venous congestion seem to cause them. An important contribution in this connection was made by Harry C. Blair in 1938. He concludes that healing of bone depends upon alternation of the circulation through the injured parts, such as occurs in normal physiological activity; and gives us a new reason for urging early and persistent physiological activity of the injured limb, rather than passive motion and physiotherapy.

Editorials and Association Notes

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Income Tax

Dr. T. C. Routley, General Secretary of the Canadian Medical Association, reports the results of a conference he had with the Dominion Commissioner of Income Tax.

War Guests: A ruling has been made that exemption from income of \$400.00 per year for each child may be made for war guest children from Great Britain only if these children have been brought out under the Government auspices. No exemption may be claimed in respect to children who have been brought out privately.

Salaried Doctors: In the income tax regulations (1940), issued recently to members of the medical profession, it is stated that salaries paid to doctors shall be taxable in full. A large number of complaints have been received by the Association to the effect that this regulation is not fair to the salaried doctor who is obliged to keep a motor car and incur other expenses incidental to the performance of his duties. The Commissioner stated that it was not the desire of the Government to collect taxes on expense money and that the remedy lay in salaried doctors having their contracts changed to provide for:—

- (a) Salary for services rendered; and
- (b) Allowance for legitimate expenses incurred in providing that service.

To illustrate, let us take the case of a salaried doctor who requires the use of a motor car in discharging his duties. It may be presumed that, in setting the salary of the doctor, due recognition was given to the fact that it was necessary for him to provide and operate a car; but, if the whole amount paid to him be declared as salary, then it is all taxable; whereas if the cost of operating the motor car is looked upon as an expense item and paid for as such, it is not salary, and therefore, is not taxable.

It is recommended that each salaried doctor concerned have his case reviewed by his employer in order that the expenses to which he is entitled may be deducted from his total income and paid to him as expenses, leaving the remainder of his income to be paid to him as salary for services rendered, upon which latter amount he will be taxed.

Microfilm Service for Medical Literature

It is now possible to obtain microfilm copies of articles from the Army Medical Library, 7th Street and Independence Avenue, Washington, D.C. The unequalled resources of the Surgeon-General's Library are available to any doctor at a cost of thirty cents for each article of thirty pages or less. A monocular viewer to read the microfilm can be obtained for \$2.00. Projectors cost \$100.00 but it is hoped they will soon be on sale for \$25.00. Alternately, a local photographer could make a projection enlargement of the microfilm at a price of about ten cents a page.

The Microfilm Service was originated by a philanthropic organization "Friends of the Army Medical Library." This group also publishes a weekly pamphlet "Current List of Medical Literature" giving the titles and authors of medical articles divided into subjects.

Obituary

DR. WILLIAM WOODHOUSE SCOTT

Dr. William Woodhouse Scott, Hazelridge, Man., died on March 19th in his seventy-ninth year. Son of the late Rev. John Scott, pioneer missionary of Emerson, Dr. Scott was born in Napanee, Ont., and came to Emerson with his parents in 1876. He graduated from Manitoba Medical College in 1895 and from then until 1916 he practised medicine in Walhalla and for the last twenty years in the municipality of Springfield, Man.

Tisdall on Nutrition

On April 14, Dr. Frederick F. Tisdall will address a public meeting in the main hall of the Winnipeg Auditorium, under the auspices of the Women's Canadian Club. His subject is, "Nutrition, what it means to the individual and the nation." In addition to his work as a paediatrician at the Toronto Sick Children's Hospital and the University of Toronto medical faculty, he is in charge of a research laboratory. He is nutrition adviser to the Department of Defence at Ottawa. It is rumoured that the British Government would like to secure his services as a nutrition expert.

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DR. L. SCOTT, Winnipeg.
DR. GEO. BROCK, Winnipeg.
DR. E. J. SKAFEL, Minnedosa.
DR. J. R. MARTIN, Neepawa.

Representatives of District Medical Societies

Southern

DR. C. C. EVERSON, Morden.
Brandon and District
DR. HERBERT MELTZER, Ninette.

North-Western

DR. GEO. CLINGAN, Virden.
North of 53
DR. N. G. TRIMBLE, The Pas.
Winnipeg Medical Society
DR. E. W. STEWART, Winnipeg.

Northern District

DR. R. E. DICKS, Dauphin.

Personal Notes and Social News

Conducted by Gerda Fremming, M.D.

Dr. Donald Whyte, of Owen Sound, Ont., was a visitor to Winnipeg for a few days, the guest of his parents, Mr. and Mrs. George Whyte, Colony Apts.

♡ ♡ ♡

Dr. and Mrs. Campbell MacArthur, of Rochester, Minn., are receiving congratulations on the birth of a daughter, March 3rd, at St. Mary's hospital, Rochester.

♡ ♡ ♡

Dr. Harry L. Chapman, of Port Arthur, Ont., was a recent guest of his parents, Mr. and Mrs. E. R. Chapman, 276 Yale avenue, Winnipeg.

♡ ♡ ♡

Dr. Joseph J. Elliott, of Chicago, Ill., son of Mr. and Mrs. George Elliott, of Winnipeg, was married March 8th to Miss Peggy Carlyle, daughter of Mr. and Mrs. Thomas Carlyle, of Winnipeg.

♡ ♡ ♡

Surgeon-Lieut. Edward A. Sellers, stationed at the Pacific coast, is spending a leave with Mrs. Sellers and his parents, Mr. and Mrs. H. E. Sellers, of Winnipeg.

♡ ♡ ♡

Dr. and Mrs. Francis A. L. Mathewson are rejoicing on the birth of a daughter, born March 16, at the Winnipeg General hospital. Squadron-leader Mathewson has been posted to the Regina Command.

♡ ♡ ♡

Dr. and Mrs. J. H. Buchanan, of Deloraine, Man., were recent visitors to Winnipeg.

♡ ♡ ♡

Dr. and Mrs. A. G. Henderson, who for the past month have been guests of Mrs. Henderson's parents, Mr. and Mrs. D. Norman Jamieson, of Winnipeg, left for New York, from where they will sail for the Belgian Congo, under the auspices of the Church of Christ.

♡ ♡ ♡

Dr. and Mrs. T. W. Shaw, of Russell, Man., were recent visitors to the city.

♡ ♡ ♡

Dr. and Mrs. Reginald W. Whetter, of Steinbach, Man., have announced the arrival of a son (Murray Clinton) on March 17th.

♡ ♡ ♡

Mrs. J. W. Kernahan, who has been the guest of her sister, Mrs. Clifford Harford, Hugo Apts., for a week, has returned to her home in Rochester, Minn.

♡ ♡ ♡

Dr. and Mrs. A. G. Meindl, Dorchester avenue, have had the pleasure of a visit from their son, Lieut. J. A. Meindl and Mrs. Meindl.

Captain Ian S. Maclean, M.O., R.C.A.M.C., son of Dr. and Mrs. Neil John Maclean, was married February 8th in London, Eng., to Miss Valerie Marie Cleary.

♡ ♡ ♡

Manitoba Medical men who recently donned uniforms are: Dr. J. D. Stirling, M.C., of Winnipeg, Dr. Harry Atkinson, Superintendent of the Home for the Aged and Infirm at Portage la Prairie, and Dr. S. Jauvoish, of Winnipeg. Dr. Stirling and Dr. Atkinson are on H.Q. staff of M.D. 10, and Dr. Jauvoish is in charge of the Portage la Prairie training centre.

♡ ♡ ♡

The *Review* is always glad to receive items of a personal or social nature for this page; however, as the *Review* goes to press a week in advance of publication date, contributions must be in by the 20th of the month preceding date of issue.

♡ ♡ ♡

If you, or I, can ultimately give to the world a single volume, or line, or thought which will enable our fellow men and women to enjoy life a little more fully, or endure it a little more easily, then we shall not altogether have laboured in vain.—IAN HAY.

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School Medical Examination

There are naturally numerous plans under which a school medical examination is organized. In some instances the examinations are done entirely in the school, some are partly in the school and partly by outside physicians, and others are done entirely outside the school.

In some localities the work is directed by the Health Department and in others by the School Board. The work itself may be carried out by full-time physicians but more frequently by part-time physicians.

Unfortunately, however, in too many districts there is no plan to provide for a physician to undertake work of this kind.

A project of this kind first came into being, probably in an effort to control communicable diseases, and was termed school medical inspection, but has now broadened into a service which attempts to influence all phases of the health of children and to forestall the diseases which may manifest themselves in adolescence. It now is called School Medical Examination and is part of a larger, broader purpose, that of public health education. Schools are educational centres and all activities in the schools have as their chief objective the education of the children and the adults in the community.

School Health Plan

The teaching of health through this channel should have a two-fold objective. First, to indicate to the individual and the community the means by which many diseases may be prevented and defects treated. Secondly, that the laity may be taught to seek from the physician a preventive service, in the same way that a curative service has for years been procured. There is not time to take up in detail the various correlated demonstrations and inclusions into the curriculum which should make up the health teaching. To merely mention some of these: there is the sanitary aspect of the school property; this does not refer solely to toilets or privys, but includes the testing of the available light at desks to see if illumination is adequate, that there is no glare in looking at the blackboards, that ventilation is controlled at proper levels, usually a temperature between 66 and 72 is comfortable; the appointment of a teacher and other staff who are in good health. Tuberculosis, for instance, has been contracted by pupils from a teacher

This might be described as preparing the school for the pupil and in so doing if the employees of the school are perchance required to undergo examination to determine their suitability, one might ask the question why are the children not required to present their credentials to show that they are fit to attend school, meaning that they are physically and mentally capable of being educated, that they do not suffer from any disease that may be transmitted, and that the recognized prophylaxis against communicable diseases has been undertaken. Such a requirement, however, is not in accord with our existing system, which relies on little else than public health education. The plans for this health education show widespread disregard of the best media of dissemination, namely the school. It is regrettable that in so many communities the school is not prepared for the pupil nor is the pupil prepared for school. The educational efforts leading to this latter requirement include the proper instruction given in Normal schools and universities to enable a teacher to undertake a minimum of class room inspection and to present the health subjects required in the curriculum. Next, there is the school nurse who acts as a liaison officer between the pupil and the parent and who must assist the school physician in "selling" the parents on

seeking medical advice about the health problems of the child which have been brought to light by the school medical service; also, and of more importance, to carry into the home the information on preventive measures that can be undertaken for this school child and for the brothers and sisters of pre-school age.

I believe that public health education in this field is everywhere receiving more and more attention, as the arguments as to when, how, and by whom, it is to be done are gradually being crystallized into a policy of a co-ordinated educational program. Some plan for a school medical examination must be included.

School Medical Examination

We all know of the findings of the medical examination of this group of our population. Griffith Binning, Saskatoon (1), reports that on the first examination of 15,105 school children only 28% were considered normal. Of the others, diseased tonsils made up 21%, and poor vision 12.7%. J. V. V. Nicholls of Montreal (2) in a survey to investigate the occurrence of abnormal ophthalmia conditions of school children in one Quebec county reports that 68.7% showed some abnormality, 29.7% of those examined were reported as suffering from subnormal visual acuity.

It is common knowledge that immunization against smallpox or diphtheria before the child enters school is usually neglected.

If this examination is an integral part of the health program, then how should it be carried out and arranged? There is as yet no complete agreement in the number of times during the child's school life that this examination should be offered, except that all appear to be agreed that the first examination should be during the first school year. In Great Britain there is imposed on the local authorities the duty of making arrangements for the medical examination of children attending school on their admission, and on such other occasions as the minister of health may direct. The frequency of the examination as a routine measure after this, varies a good deal in different districts. Some advocate a yearly routine examination, but the necessity for this as an educational measure is to be questioned. The school medical examination should be considered as a fact-finding process and should be approached with the idea that it is part of the health program or plan for health education through the school. Unfortunately, it is a fact that frequently this procedure is carried out in a most cursory manner. It is a poor introduction to this examination for the child to be lined up outside the examining room in the school waiting for the physician to arrive, then a moment or two after the first pupil goes in to hear announced to all and sundry that "This child has terrible tonsils. Tell the mother they should be taken out," and in a minute or two to hear, "Next, hurry up," or some other such remark, which is very likely to leave an undesirable impression on the child. Stereotyped or endless belt examinations are unsatisfactory and a waste of time and money; usually no arrangement for consultation with parent has been made but a card marking the defect is probably sent to the home. The result, insofar as education is concerned, is negligible and the correction of defects poor.

The success of the examination of small children is dependent on the presence of the parent in order that the physician may discuss with the parent the past history and background of the child, the findings of the medical examination and the carrying out of preventive or corrective procedures. This, of course, is a time-consuming plan, and may require modification under some circumstances.

The medical examination usually covers the following:

1. Nutrition. In evaluating this the knowledge of how a child's present weight compares with his weight in the past, of what and how he eats, how and how much he sleeps, is of much more value than to know only his present weight, height and age figures.

2. Defects of Vision. This is usually first discovered by the simple test of reading an eye chart at 20 feet. This is an important contribution, as it may interfere with the learning process.

3. Hearing Defects. Much the same applies to hearing. In recent years this is done by electrical audiometry, being specially suited to group testing.

4. Posture and other orthopedic disabilities.

5. State of the nose and throat. Here there is, of course, considerable difference of opinion whether a pair of tonsils require further investigation.

6. Cardiac conditions.

7. Anaemia.

8. Skin Diseases.

9. Dental Caries.

10. Glandular Dyscrasias.

11. Mental Attitudes—term is used in its broadest sense, should be discussed separately, for which there is no time here. Examinations should be carried out by competent psychiatrist.

12. We may also include here the question of immunization against certain communicable diseases.

In 1937 the Committee on School Health and School Health Education of the American Academy of Pediatrics proposed the following five principles for guidance in the development of medical services for public schools:

1. The school medical services should be thoroughly co-ordinated with the other community medical facilities.

2. The advice which is given to parents, pupils or school staff should meet the best medical standards.

3. The services of the physician in the school should contribute to sound education.

4. The examination should provide records that are readily interpreted by those who use them and permit the follow-up service to give first attention to the more serious cases.

5. The detection of defect cases should be made with economy of effort and financial cost.

The extent of this medical examination is probably sufficient for this purpose. It must be recognized that it has its limitations. It should not be looked upon as a service, and it is not intended to assume the role of a diagnostic clinic such as is available in a hospital clinic or in the offices of many physicians.

Records

The information thus obtained should be properly recorded and made easily available for future use. Any unusual condition disclosed by the examination should be discussed with the child's teachers. The teacher needs to know as much as possible about the children in her class. In other words the medical examination loses the greater part of its value unless the findings are used to help the child take full advantage of the academic curriculum, and to teach prevention to the child and in the home.

Medical Examination Outside the School

In some sections of the United States the effort has gone one step further with the idea of getting the school children both examined and treated outside the school, and at the same time indicating more clearly

the desirability of having medical examinations during the pre-school years. This is exemplified by an experiment in Missouri and described by Dr. T. R. Myer (3), St. Louis County Health Commissioner, "Transfer the examinations from the school to the family physician's office. There are various reasons for this, the chief one being that young children cannot go alone to the physician's office, but must be accompanied by their parents. Through the co-operation of the Medical Society the physicians agreed to make medical examinations of entering school children in their offices at designated hours. Entering school children include children in kindergarten and in the first grade who have not attended school before. All the family physicians participating in this plan give medical examinations to entering school children without charge regardless of the family ability to pay. The child presents an identification card with a medical examination certificate on the reverse to be signed by the physician.

"Results of the St. Louis County program as indicated in the first three years of operation:

"1. Education of parents to take their children to a physician's office, and to establish early in the children's lives the habit of seeking medical supervision.

"2. Correction of physical defects in an increasingly high percentage of cases."

Education should be in the school, medical treatment and advice should be by the physician, but his role should not be entirely passive, being content to minister to those who come for corrective treatment or preventive therapy on the recommendation of the purely educational organization.

The physician himself can, I think, take advantage of many opportunities of advising or suggesting preventive measures for school and pre-school children among the families he attends. Even if no definite action results from his various reminders, the result is to make the parents susceptible to the same advice when it comes from the school health services. Judging from the reports on the examination of first grade school children, prevention among the pre-school group must surely be widely neglected. The proper cultivation of this field should prove most profitable from both the individual and community point of view.

Some Reasons for Discussing this Question

1. A school health program with proper medical examination to be available is more and more being recognized as essential and as being part and parcel of the school education system.

2. The trend of medicine and of medical practice is more and more toward prevention.

3. The Canadian Public Health Association appear to be interested in school health teaching, as a questionnaire has been circulated to Normal school principals as to the instruction given to their students in that subject.

4. Medical examination of a large sample group of the young people of rural Manitoba revealed that roughly 70% (4) had one or more remedial defects, this included 42% with visual defect, and about 3% with signs very suggestive of early rickets.

5. Recruits into the active service units of the militia and the air force reveal defects which make enlistment inadvisable.

6. During June, July and August, 1940, there were 6,743 recruits examined for the regular army of the U.S.A. in the Southern New York District (5). 32.5% were rejected, mainly because of teeth, eyes, height and weight, which included undernourishment, feet and ears. The report ended as follows: "It is also hoped that some preventive and remedial measures may be instituted for the better preservation of the health of the youth of a nation. As a national defense measure this is of vital importance for the future."

7. In Manitoba, although there is instruction in

health teaching in the Normal school and provision for it in the school curriculum, that effort is largely nullified because in most instances the remaining component parts of the health plan are absent. In too many cases the school structure and equipment does not lend itself for use as an example of proper, comfortable and healthful living; in only a few schools is there any effort at school medical examination or a nursing service.

Forty-six municipalities report an arrangement for school medical examination, but the details of the arrangement or the extent of its correlation to school teaching is not available, and 29 have a public health nurse.

It is not to be inferred that every defect found in adolescence or as a refusal for enlistment could have been prevented in childhood. Nevertheless, there is insufficient application during childhood of well-known prophylactic measures which is a clear indication of the relative lack, or failure of health teaching or education.

In conclusion may I state that the furtherance of this effort requires behind it the combined authority of the municipalities and Departments of Education, the work and co-operation of the physicians and organized Medical Societies, and the administrative advice of the Departments of Health.—C.R.D.

- (1) Griffith Binning—Can. Pub. Health JI.—January, 1938.
- (2) J. V. V. Nicholls—Can. Med. Ass'n. JI.—June, 1940.
- (3) T. R. Myer, M.D.—Dr. P. H. Family Physician co-operates with the Health Dept. The Child—October, 1940.
- (4) A Health Survey of Rural Manitoba Youth—Compiled by Cecil Sheps, M.D.—1940.
- (5) Causes of Rejection for Entrance Into the Regular Army—Geo. E. Lione, M.D., J.A.M.A.—Oct. 12, 1940.

COMMUNICABLE DISEASE REPORT January 28 to February 25, 1941

Measles: Total 815—Portage City 134, Winnipeg 116, Brandon 95, Minnedosa 39, Louise 23, St. Boniface 21, Edward 19, Flin Flon 18, Unorganized 18, Roblin Rural 15, Portage Rural 13, Pilot Mound 13, Silver Creek 13, Norfolk North 12, Pembina 12, Ethelbert 11, Melita 11, Miniota 10, Hamiota Rural 9, Minto 8, Wallace 8, Boissevain Town 7, Hartney 7, Cypress South 6, McCreary 6, Teulon 6, Cartier 5, Oak Lake Town 5, Harrison 5, St. Clements 5, Argyle 4, St. James 4, Sifton 4, Birtle Town 3, Lac du Bonnet 3, Neepawa Town 3, Whitehead 3, Whitemouth 3, Albert 2, Arthur 2, Hamiota Village 2, Norfolk South 2, Rosser 2, Russell Town 2, St. Vital 2, Shoal Lake Village 2, Souris 2, Virden 2, Woodlands 2, Assiniboia 1, Carberry 1, Daly 1, De Salaberry 1, Fort Garry 1, Gilbert Plains Rural 1, Gilbert Plains Village 1, Kildonan West 1, Lakeview 1, Manitou Village 1, Morris Town 1, Rivers Town 1, Roblin Town 1, Rockwood 1, St. Rose Rural 1, Selkirk 1, Transcona 1. (Late Reported: Birtle Rural 19, Birtle Town 17, Fox-warren 15, Roblin Rural 9, Hartney 6, Neepawa 3, Norfolk South 1, Brandon 1, Cartier 1, Flin Flon 1, Glenwood 1, Harrison 1, Norfolk North 1, Portage Rural 1, Portage City 1, Wallace 1.)

German Measles: Total 516—Brandon 264, Kildonan East 41, Edward 35, Arthur 30, Unorganized 29, Melita 25, Norfolk North 14, Portage City 10, St. Clements 10, Deloraine 9, Kildonan West 9, Winchester 8, Manitou 4, Napinka Village 4, Pembina 4, Harrison 3, Rosser 2, St. Boniface 2, Selkirk 2, Brenda 1, Portage Rural 1, St. Vital 1, Saskatchewan 1, Strathclair 1, Transcona 1. (Late Reported: Brandon 5).

Chickenpox: Total 126—Winnipeg 66, Boissevain Town 10, St. James 7, Lawrence 6, Unorganized Territory 5, Kildonan East 4, St. Boniface 4, Fort Garry 3, Roblin Rural 3, Rosser 3, Portage City 2, Arthur 1, MacDonald 1, Melita 1, Oak Lake Town 1, Rivers Town 1, Rockwood 1, Turtle Mountain 1. (Late Reported: St. Francois Xavier 4, Lawrence 1, Oak Lake 1.)

Mumps: Total 101—Winnipeg 68, Flin Flon 8, St. Boniface 7, Rosser 5, St. James 3, Brandon 1, Hamiota Village 1, Kildonan East 1, Rockwood 1, Cypress South 1, Transcona 1. (Late Reported: Flin Flon 4.)

Whooping Cough: Total 66—Unorganized 35, Winnipeg 15, Cameron 2, Beausejour 1, Boissevain Town 1, Grey 1,

Hanover 1. (Late Reported: Brandon 3, North Norfolk 2, Virden 1, Unorganized 1, Grey 1, Hanover 1, Lac du Bonnet 1.)

Tuberculosis: Total 37—Winnipeg 5. (Late Reported: Unorganized 9, Dauphin Town 3, St. James 3, Coldwell 2, De Salaberry 2, Bifrost 1, Cypress North 1, Franklin 1, Morris Rural 1, Piney 1, Rhineland 1, St. Boniface 1, Selkirk 1, Siglens 1, Swan River Rural 1, Tache 1, The Pas 1, Whitemouth 1.)

Influenza: Total 36—Carberry 7, Winnipeg 7, Portage City 5, Portage Rural 1, Rosedale 1, Sifton 1, Unorganized 1. (Late Reported: Portage City 2, Bifrost 1, MacDonald 1, Argyle 1, Brandon 1, Brenda 1, Minnedosa 1, Portage Rural 1, St. Clements 1, St. Vital 1, Swan River Rural 1, Carberry 1.)

Scarlet Fever: Total 29—Winnipeg 8, Portage City 3, St. Boniface 3, St. James 3, Portage Rural 2, Brandon 1, Ethelbert 1, La Broquerie 1, McCreary 1, Roblin Rural 1, Transcona 1, Unorganized 1. (Late Reported: Unorganized 3.)

Diphtheria: Total 27—Winnipeg 13, Unorganized 6, St. Boniface 2, Lawrence 1. (Late Reported: Unorganized 5.)

Pneumonia Lobar: Total 19—Rosedale 2, Lawrence 1, Manitou Village 1, Mossey River 1, St. Rose Rural 1, St. Vital 1, Unorganized 1. (Late Reported: Franklin 1, St. Clements 1, Ste. Rose Rural 1, Boulton 1, Hanover 1, Lawrence 1, Rhineland 1, St. Anne 1, St. Boniface 1, Whitemouth 1, St. James 1.)

Meningococcal Meningitis: Total 5—Winnipeg 1, Ethelbert 1, Tache 1, Transcona 1. (Late Reported: Roland 1.)

Erysipelas: Total 5—Winnipeg 4, Arthur 1.

Puerperal Fever: Total 3—Gilbert Plains Rural 1. (Late Reported: Unorganized 1, De Salaberry 1.)

DEATHS FROM COMMUNICABLE DISEASES January, 1941

URBAN—Cancer 40, Pneumonia Lobar 7, Pneumonia (other forms) 10, Tuberculosis 9, Influenza 8, Syphilis 2, Lethargic Encephalitis 1. Other deaths under one year 18, other deaths over one year 176; Stillbirths 5. Total 281.

RURAL—Influenza 18, Pneumonia Lobar 4, Pneumonia (other forms) 18, Cancer 12, Tuberculosis 9, Measles 3, Whooping Cough 2, Poliomyelitis 1, Syphilis 1, Chickenpox 1. Other deaths under one year 21, other deaths over one year 131; Stillbirths 8. Total 229.

INDIAN—Tuberculosis 3, Pneumonia 3, Influenza 2. Other deaths under one year 3, other deaths over one year 6, Stillbirths 2. Total 19.

DEATHS FROM COMMUNICABLE DISEASES 1940 Registrations Received in January, 1941

RURAL—Pneumonia Lobar 2, Pneumonia (other forms) 3, Cancer 2, Influenza 1, Puerperal Septicaemia 1, Tuberculosis 1. Other deaths under one year 4, other deaths over one year 31; Stillbirths 6. Total 51.

URBAN—Tuberculosis 2, Pneumonia Lobar 1. Other deaths under one year 3, other deaths over one year 7; Stillbirths 1. Total 14.

INDIAN—Tuberculosis 8, Typhoid Fever 2, Diphtheria 1. Other deaths under one year 2, other deaths over one year 10. Total 17.

COMMUNICABLE DISEASES REPORTED IN TERRITORY CONTIGUOUS TO MANITOBA

Disease	Manitoba Jan. 29, '41-Feb. 26, '41	Ontario Jan. 26, '41-Feb. 22, '41	Saskatchewan Jan. 26, '41-Feb. 22, '41	Minnesota Jan. 26, '41-Feb. 22, '41
Anterior Poliomyelitis				2
Meningococcal Meningitis	4	48	5	3
Chickenpox	120	1,251	110	506
Diphtheria	22	8	11	9
Erysipelas	5	10	1	1
Influenza	23	1,076		3,110
Measles	736	3,346	1,601	36
German Measles	511	5,418	836	
Mumps	97	707	62	
Scarlet Fever	26	651	38	193
Septic Sore Throat		38	5	
Smallpox				39
Trachoma			2	
Tuberculosis	5	183	28	140
Typhoid Fever		5		
Para-typhoid Fever		2		
Undulant Fever		6		
Whooping Cough	56	695	111	215

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